

Semi-Independent Living Services Protocol Checklist

Person's Name _____
(Last, First)

Date of Birth _____

Reviewer's Name _____
(Last, First)

Appeals Submission Date _____

NOTE: This residential service option is ONLY available to individuals enrolled in the Self-Determination Waiver.

This service option allows flexibility for the person to change to a residential, semi-independent living arrangement. The Department will assist in cases where the person needs to change from a different waiver into the Self-Determination waiver in order to receive this residential service option.

Technical Review

<input type="checkbox"/> YES <input type="checkbox"/> NO	<p>Is the correct funding source, site code and service code used in Section C of the ISP?</p> <p>If YES, continue to Question #1 in Section A, B or C as applicable.</p> <p>If NO and the wrong funding source, site code and service code is due to a simple error, correct the error and continue to Question #1 in Section A, B or C as applicable.</p> <p>If NO based on lack of a site code because the provider is not licensed or does not have an approved provider agreement, deny as non-covered due to failure to meet provider qualifications as specified in the SD Waiver and in the TennCare rules applicable to the waivers.</p>
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A. Initial Semi-Independent Living Services

<p>1.</p> <p>a. <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>Medical necessity review questions:</p> <p>a. Is there sufficient information in the ISP and supporting documentation to show that the person:</p> <p>(1) Is independent with basic activities of daily living (i.e., fundamental self-care tasks such as bathing, dressing, chewing and swallowing food, and assistance with toileting); AND</p> <p>(2) Requires assistance with one or more of the following:</p> <p>(a) Instrumental activities of daily living (activities which are not necessary for fundamental functioning, but are necessary for an individual to live independently in the community (e.g., training and assistance with managing money, preparing</p>
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<p>b. <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>c. <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>meals, shopping, health management and maintenance); OR</p> <p>(b) Interpersonal and/or social skills building; OR</p> <p>(c) Other activities that are needed to improve the person's capacity to live in the community; AND</p> <p>(3) Has a level of independence and personal safety which only requires intermittent or limited support to live independently in their own home; AND</p> <p>(4) Does not require support staff to live in their home; AND</p> <p>(5) If applicable, is capable of medication self-administration with minimal oversight and assistance; AND</p> <p>(6) If applicable, with proper supports (behavioral or otherwise) can safely and successfully maintain a semi-independent living arrangement; AND</p> <p>b. Is there sufficient information in the ISP and supporting documentation which describes the routine supports (including access to emergency supports as needed from the provider on a 24/7 basis) which will be provided by the residential staff; AND</p> <p>c. Is there sufficient information in the ISP and supporting documentation to show at least one of the following:</p> <p>(1) The person's need for direct support services and other services can not be safely and effectively met in the home for one of the following reasons:</p> <p>(a) The person resides in a home with family members and:</p> <p>i. The caregiver(s) died; OR</p> <p>ii. The caregiver(s) became physically or mentally incapacitated and can no longer reasonably provide caregiver services; OR</p> <p>iii. It is unsafe for the person to remain in the home due to abuse or neglect by the caregiver(s) or by other individuals residing in the home; OR</p> <p>(b) The person resides in a home with individuals other than family members, and:</p> <p>i. The caregiver(s) are no longer willing or able to provide caregiver services; OR</p> <p>ii. It is unsafe for the person to remain in the home due to abuse or neglect by the caregiver(s) or by other individuals residing in the home; OR</p>
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	<p>(c) The person is currently homeless, will be homeless within 30 days due to eviction, or is being discharged from a hospital or other institution or custody of the Department of Children's Services and the person does not have family members or others who are willing or able to provide a place of residence; OR</p> <p>(d) The provision of in-home services (e.g., Personal Assistance) is not sufficient to safely support the individual in the community, because the person requires the availability of emergency supports as needed on a 24/7 basis; OR</p> <p>(2) It is more cost-effective to meet the person's needs for direct support services and other services through a waiver residential service rather than through the provision of other waiver services in the person's home or in a home with family members or other caregivers?</p> <p>If YES to "1.a.", "1.b." and "1.c.", stop and approve Semi-Independent Living Services.</p> <p>If NO to either "1.a.", "1.b." or "1.c.", stop and deny as not medically necessary.</p>
<input type="checkbox"/> Approved	
<input type="checkbox"/> Denied	
Reviewer signature and date	

B. Continuation of Semi-Independent Living Services in the Same Home

<p>1.</p> <p>a. <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>Medical necessity review questions:</p> <p>a. Is there sufficient information in the ISP and supporting documentation to show that the person <i>continues</i> to:</p> <p>(1) Be independent with basic activities of daily living (i.e., fundamental self-care tasks such as bathing, dressing, chewing and swallowing food, and assistance with toileting); AND</p> <p>(2) Require assistance with one or more of the following:</p> <p>(a) Instrumental activities of daily living (activities which are not necessary for fundamental functioning, but are necessary for an individual to live independently in the community (e.g., training and assistance with managing money, preparing meals, shopping, health management and maintenance); OR</p>
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<p>b. <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>c. <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>(b) Interpersonal and/or social skills building; OR</p> <p>(c) Other activities that are needed to improve the person's capacity to live in the community; AND</p> <p>(3) Have a level of independence and personal safety which only requires intermittent or limited support to live independently in their own home; AND</p> <p>(4) Not require support staff to live in their home; AND</p> <p>(5) If applicable, be capable of medication self-administration with minimal oversight and assistance; AND</p> <p>(6) If applicable, with proper supports (behavioral or otherwise) safely and successfully maintain a semi-independent living arrangement; AND</p> <p>b. Is there <i>still</i> sufficient information in the ISP and supporting documentation which describes the routine supports (including access to emergency supports as needed from the provider on a 24/7 basis) which will be provided by the residential staff; AND</p> <p>c. Is there sufficient information in the ISP and supporting documentation which provides proof that the minimum requirement of two (2) face-to-face visits in the home per week (with a maximum number to be determined by the person's needs) <i>have been held</i> with the person as required, in which the documentation ensures that:</p> <p>(1) Semi-Independent Living Services continue to be the most appropriate residential setting for the person; AND</p> <p>(2) The person's needs continue to be safely and effectively met in Semi-Independent Living Services?</p> <p>If YES to "1.a.", "1.b." and "1.c.", stop and approve continuation of Semi-Independent Living Services.</p> <p>If NO to either "1.a.", "1.b." or "1.c.", stop and deny continuation of Semi-Independent Living Services as not medically necessary.</p>
<input type="checkbox"/> Approved	
<input type="checkbox"/> Denied	
Reviewer signature and date	

C. Continuation of Semi-Independent Living Services AND Transfer to a Different Semi-Independent Living Services Home

<p>1.</p> <p>a. <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>b. <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>c. <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>Medical necessity review questions:</p> <p>a. Is there sufficient information in the ISP and supporting documentation to show that the person continues to:</p> <ul style="list-style-type: none"> (1) Be independent with basic activities of daily living (i.e., fundamental self-care tasks such as bathing, dressing, chewing and swallowing food, and assistance with toileting); AND (2) Require assistance with one or more of the following: <ul style="list-style-type: none"> (a) Instrumental activities of daily living (activities which are not necessary for fundamental functioning, but are necessary for an individual to live independently in the community (e.g., training and assistance with managing money, preparing meals, shopping, health management and maintenance)); OR (b) Interpersonal and/or social skills building; OR (c) Other activities that are needed to improve the person's capacity to live in the community; AND (3) Have a level of independence and personal safety which only requires intermittent or limited support to live independently in their own home; AND (4) Not require support staff to live in their home; AND (5) If applicable, be capable of medication self-administration with minimal oversight and assistance; AND (6) If applicable, with proper supports (behavioral or otherwise) safely and successfully maintain a semi-independent living arrangement; AND <p>b. Is there still sufficient information in the ISP and supporting documentation which describes the routine supports (including access to emergency supports as needed from the provider on a 24/7 basis) which will be provided by the residential staff; AND</p> <p>c. Is there sufficient information in the ISP and supporting documentation which provides proof that the minimum requirement of two (2) face-to-face visits in the home per week (with a maximum number to be determined by the person's needs) have been held with the person as required, in which the documentation ensures that:</p> <ul style="list-style-type: none"> (1) Semi-Independent Living Services continue to be the most appropriate residential setting for the person; AND
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	<p>(2) The person's needs continue to be safely and effectively met in Semi-Independent Living Services?</p> <p>If YES to "1.a.", "1.b." and "1.c.", stop and approve continuation of Semi-Independent Living Services.</p> <p>If NO to either "1.a.", "1.b." or "1.c.", stop and deny continuation of Semi-Independent Living Services as not medically necessary.</p>
<input type="checkbox"/> Approved	
<input type="checkbox"/> Denied	
Reviewer signature and date	